STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155568	A. BUII	a. BUILDING 00			COMPLETED 03/01/2012	
		100000	B. WIN			03/01/	2012	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE ORT ST			
WILLIAM	ISPORT NURSING	S AND REHABILITATION			MSPORT, IN 47993			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG F0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
1 0000								
	State Licensure included the Inv IN00104198. Complaint IN00 due to lack of ev Survey dates: Fe March 1, 2012 Facility number Provider number AIM Number: 1 Survey Team: Meather Lay, RN Janet Stanton, R Rita Mullen, RN Michelle Carter Census bed type	ebruary 27, 28, 29, & : 000449 rr: 155568 00290350 Michelle Hosteter RN-TC N RN N , RN	F00	00	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. Provider desires that the 2567 plan of correction be considered the letter of credibiallegation and requests a desireview certification of compliant on or after 03-30-2012.	ot s : n of at e le k		
	SNF/NF: 64							
	Total: 64							
	Census payor ty Medicare: 10 Medicaid: 44 Other: 10 Total: 64	rpe:						
	Sample: 15							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000449

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI 03/01/2	ETED		
	PROVIDER OR SUPPLIER SPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE		
			CROSS-REFERENCED TO THE APPRO	PRIATE			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155568	A. BUILDING	00	COMPLETED 03/01/2012
		155566	B. WING		03/01/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
WILLIAN	ISPORT NURSING	AND REHABILITATION		HORT ST AMSPORT, IN 47993	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been foun neglecting, or m of law; or have I State nurse aide neglect, mistrea misappropriatio any knowledge law against an eindicate unfitnes or other facility registry or licens. The facility mus violations involvabuse, including and misapproprieported immed the facility and t with State law the	REPORT //INDIVIDUALS t not employ individuals who d guilty of abusing, histreating residents by a court had a finding entered into the registry concerning abuse, htment of residents or h of their property; and report it has of actions by a court of employee, which would ss for service as a nurse aide staff to the State nurse aide			
	The facility mus alleged violation and must preve while the investion. The results of a reported to the adesignated reprofficials in accordincluding to the agency) within a sand if the allege appropriate cordinated on recording to the agency appropriate cordinated and if the allege appropriate cordinated and recordinated and re	-	F0225	F225 Investigate/Report Allegations/IncidentsThe facili must not employ individuals w	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155568	B. WIN	G		03/01/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORT ST		
WILLIAM	WILLIAMSPORT NURSING AND REHABILITATION			WILLIAI	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	1
TAG		LSC IDENTIFYING INFORMATION)	_	TAG		DATE	
	_	mediately to the facility			have been found guilty of abusing, neglecting, or		
	Administrator, Director of Nursing, or				mistreating Residents by a cou	ırt	
		r. The deficient practice			of law; or have had findings		
	impacted 2 of 2 s	supplemental residents			entered into the State nurse ai	de	
	[Residents #6 an	d #15] reviewed for			registry concerning abuse,		
	alleged abuse vio	plations from a sample of			neglect, mistreatment of	of	
	15 residents revi	ewed. The facility failed			Residents or misappropriation their property; and report any	OI	
	to report an unus	ual occurrence to Indiana			knowledge it has of actions by	a	
	State Departmen	t of Health. The			court of law against an employ	ee,	
	deficient practice impacted 1 of 1 residents reviewed for elopement from a				which would indicate unfitness		
					services as a nurse aide or oth	er	
	sample of 15 resi	-			facility staff to the State nurse aide registry or licensing		
	[Resident #31]				authorities. The facility must		
	[ensure that alleged violations		
	Findings include				involving mistreatment, neglec	t,	
	1 mamgs merade	•			or abue, including injuries of		
	1. On 2-29-12 at	t 0:45 A M the			unknown source and misappropriation of Resident		
		ovided the facility's			property are reported immedia	tely	
	•	_			to the administrator of the facil		
		vestigation for Residents			and to other officials in		
		hat time, a "Facility			accordance with State law		
	Incident Reportii	ng Form" was reviewed.			through established procedure (including to the State survey a		
	(F) (F) (1) *	:1 (D (: D !!			certification agency)The facility		
		ident Reporting Form"			must have evidence that all		
					alleged violations are thorough	•	
	_	-					
		C					
	Council meeting	it was identified that			be reported to the administor of		
	[Certified Nursing Assistant #3] [CNA] had become rough with a couple of residents [Resident #6 and #15] during their shower. When questioned rough, residents replied with rushing through the				his designated representative		
					· · · · · · · · · · · · · · · · · · ·	of	
					the incident, and if the alleged		
	1	ate Action Taken:			violation is verified appropriate		
	included, but wa Date: 12-19-11 a Involved: [Resident Description of In Council meeting [Certified Nursing had become rough residents [Resident their shower. Was residents replied]	s not limited to, "Incident at 2:20 P.M Residents dents #6 and #15] Brief acident: During Resident it was identified that ag Assistant #3] [CNA] sh with a couple of ent #6 and #15] during hen questioned rough, with rushing through the			alleged violations are thorough investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administor of his designated representative to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days the incident, and if the alleged	e e e e e e e e e e e e e e e e e e e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155568	B. WIN			03/01/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	L			ORT ST	
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	Employee in question [CNA #3] was				action must be taken.What corrective actions will be	
	suspended for 3 days pending				accomplished for those Reside	ents
	investigation, in	vestigation initiated			found to have been affected by	l l
	immediately by	Executive Director [ED]			the defecient practice?1.)	
	and Social Servi	ce Director [SSD],			Resident #6 and #15 had no	
	Resident's interv	iewed with no findings,			negative adverse reactions an	d/or
	Residents [Residents #6 and #15] who initially reported that she was rough indicated during interview conducted by				no negative psycho-social distress from the allegations.	
					Both Resients identified	
					acknowledged they had not be	een
	SSD that she was not rough, staff interviewed with no findings to support				abused.2.) Residents have be	en
					informed to report any allegation	
	any allegation of roughness Preventive				of abuse to anyone of the staff	f/or
	1 -	Abuse in-service			the Executive Director for investigation during the Reside	ont
					Council meeting 03-16-12.Hov	
		ursday, December 22,			other Residents having the	`
		estion was allowed to			potential to be affected by the	
	return to work ba				same deficient practice will be	
	evidence The "	Facility Incident			identified and what corrective	
	Reporting Form'	' was submitted to			actions will be taken?1.) All	
	Indiana State De	partment of Health on			Residents have the potential to be affected2.) No other Reside	
	12-19-11.				was affected or identified3.) Al	l l
					allegations of abuse will be	
	The facility inve	stigation of the alleged			investigated and reported to the	ne
	<u> </u>	out was not limited to the			ISDH within 24 hours by the	
	following inform				Executive Director/or designeeWhat measures will be	10
					put into place to ensure that th	
	A document title	d, "Monday December			deficient practice does not	
		document included, but			recur?1.) Activity Director was	l l
	l '	o, "2:30 P.M. Director of			provided 1:1 in0service educa	tion
					by teh Executive Directr on	
	Nursing Service [DNS] received written concern report from December [2011] Resident Council meeting minutes stating couple of resident[s] stated that one of the				12/19/11 & 03/14/12 and reprimanded on 12/19/11 for n	unt
					following facility abuse protoco	l l
					All staff was re-educated by th	
					Executive Director on 03/14/12	
		is a little rough with			regarding facility abuse	
	them while givin	g care Following			prohibition policy (See attachn	nent

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155568	B. WIN			03/01/2012
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			ORT ST	
WILLIAM	ISPORT NURSING	AND REHABILITATION			MSPORT, IN 47993	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	notification of th	ne meeting minutes,			1-1)3.) Resident Council was	
	[CNA #3] was w	valked out of the		1	informed by the Executive	
	building ED ar	nd SSD began			Director on 03/16/12 to contact anyone on staff to report any	:(
	interviewing resi	idents from both halls a			allegation of abyse or if they d	0
		interviewed in addition to			not feel comfortable telling	
ı		ents interviewed indicated			anyone that they may come to	the
	that they had no				Executive DirectorHow the	. [
	-	CNA #3] as previously			corrective action will be monito	
					to ensure the defecient practic will not recur?1.) Executive	, c
	indicated in Resident Council Activity Director who leads Resident Council was out of the building during the				Director/or designee will rando	omly
					interview staff members about	
					abuse policies and procedures	3
		Jpon return to the			weekly for 4 weeks using the	
	-	gave a 1:1 inservice with			Continuous Quality Improvement	
		ector that reminded her			tool, then radomly interview st members bi-weekly for 30 day	
	that any allegation	on of abuse that has been			then quarterly. The results of	
	identified in Res	ident Council will be			these interviews will be review	red
	brought to attent	ion of the ED			by the CQI committee oversee	
	immediately foll	lowing the Council			by the Executive Director. If 10	
	meeting or after	any allegations are			compliance is not achieved an action plan will be developed t	
	made Head to	toe assessments were			ensure compliance. (See	0
	completed with	no areas noted"			attachment 1-2)2.) Completion	n
	1	•			Date: 03/30/12	
	During daily exi	t conference on 2/28/12 at				
		lent Council minutes				
	· ·	ove incident were				
		ove meldent were				
	requested.					
	On 2/20/12 at 0.	15 A.M. Resident				
	On 2/29/12 at 9:45 A.M., Resident Council minutes for December 2011 were received from the Administrator. The "Resident Council Minutes" dated					
ı						
	12/13/11, no tim	e, included, but were not				
	limited to, "One	resident expressed to				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155568			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI 03/01	LETED	
		155568	B. WIN			03/01	/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
14/11 1 14 8 4	ODODE NUIDOINO	AND DELIABILITATION			ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE PRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		NA [CNA #3] is a little					
	rough when giving her a shower. When						
	•	she hurt you in any way					
	resident stated no	she seems very strong					
	and has a very m	anly voice Residents					
	were asked to alv	ways report it if they feel					
	threatened in any	way. This resident					
	stated I shouldn't	have said anything.					
	Resident redirect	ted to always voice their					
	opinions about a	buse topics. Resident					
	stated I wasn't abused"						
	The Activity Dir	ector was informed by					
	Resident #6 and	•					
	12/13/11. no tim	e, during the monthly					
		l meeting of an allegation					
		ctivity Director informed					
		llegation 6 days later on					
	12/19/11.	negation o days later on					
	12/17/11.						
	On 3/1/12 at 11:	30 A.M., Resident #6's					
	record was revie	·					
		· ·					
		re not limited to, diabetes					
		depression, hypertension,					
	and congestive h	eart failure.					
	A anominal - 1 Min :	mum Data Cat [MDC]					
		mum Data Set [MDS]					
	_	ment dated 12/1/11					
	· ·	s not limited to, "BIMS					
	[Brief Interview Mental Status] 14						
[cognitively intact], Bathing total assist with one person"							
	0.04/50	40 4 3 6 D 11 1 11 5 7					
	On 3/1/12 at 11:4	40 A.M., Resident #15's					

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		155568	A. BUILDIN B. WING	G		03/01/	2012
	PROVIDER OR SUPPLIER	AND REHABILITATION	20	00 SHC	DDRESS, CITY, STATE, ZIP CODE DRT ST MSPORT, IN 47993		
					/ISPORT, IN 47993	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	depression, and h A quarterly MDS	re not limited to, anxiety, hypertension. S screening assessment				·	
	limited to, "BIM	cluded, but was not S 13 [cognitively intact], help with one assist"					
	2/27/12 at 10:45 Resident #31 was interviewable, an	cility was initiated on A.M. with the DNS. s described as anbulated with a rolling anderguard for elopement					
	indicated Resider elope from the fa therefore the war again. She indicated facility with a fri apartments located indicated Resider wanderguard in the	t that time, the DNS nt #31 had attempted to ucility 1-2 months ago nderguard was placed atted Resident #31 left the end who lived in the ed on the property. She nt #31 had worn a he past; however, his proved since that time nt behaviors.					
	record was reviewincluded, but we obstructive pulm	re not limited to, chronic					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155568		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPL 03/01/	ETED
WILLIAN	PROVIDER OR SUPPLIER ISPORT NURSING AND REHABILITATION	STREET A 200 SH WILLIA	ADDRESS, CITY, STATE, ZIP CODE ORT ST MSPORT, IN 47993	.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	An "Elopement Risk Assessment" dated 4/16/11 included, but was not limited to, "Resident has a history of eloping from home or facility yes, Resident experiences increased confusion at certain times of the day yes, Resident walks/paces about the facility and is often seen trying to open exit doors yes, Resident has been assigned a security bracelet [wanderguard] yes" A "Physician's Orders" dated 8/11/11, no time, included, but was not limited to, "May discontinue wanderguard Care plan update, no exit seeking behavior" A "Social Service Progress Notes" dated 11/4/11, no time, included, but was not limited to, "Resident quarterly Minimum Data Set [MDS] completed Brief Mental Status [BIMS] is 12 [moderately cognitively impaired] Resident scored higher on this BIMS than in the past Resident states he gets fidgety and restless due to being out working instead of sitting in the facility Resident is active and social" A "Progress Notes" dated 12/9/11 at 6:35 P.M., included, but was not limited to, "Resident alert and oriented to person, place, and time Does have memory deficit				

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	OF CORRECTION IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/01/2012			
	PROVIDER OR SUPPLIER ISPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	A "Progress Notes" dated 1/22/12 at 2:02 P.M., included, but was not limited to, "Wanderguard working and placement verified, no exit seeking noted" A "Physician's Orders" dated 1/22/12, no time, included, but was not limited to, "Wanderguard placement due to new elopement assess [sic] and triggers Also history of elopement attempts Care plan update, potential for exit seeking" A "Progress Notes" dated 1/23/12 at 2:23 P.M., included, but was not limited to,						
	"Resident's annual MDS completed at this time BIMS 8 [cognitively moderately impaired] Resident's care plans focus on full code, long term, and elopement risk"						
	A "Observation Report" dated 1/23/12 at 9:35 A.M., included, but was not limited to, "Elopement Risk Assessment: Resident has history of eloping from home or facility yes, Resident experiences increased confusion at certain times of the day yes, Resident walks/paces about the facility and is often seen trying to open exit doors yes, Has the resident been assigned a security bracelet yes"						
	In an interview 2/29/12 at 11:15 A.M.,						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155568	B. WIN	G		03/01/	2012
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION		WILLIAI	MSPORT, IN 47993		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		strator regarding Resident					
		attempt on 1/22/12, he					
		nt #31 was let out of the					
	I	sekeeper who no longer					
		eility. The Administrator					
		nt #31 was with a friend					
		apartments located on the					
		He indicated Resident					
		riend home and the					
	housekeeper let him out of the facility,						
	informed the nurse working who then						
	informed the Administrator. The						
	Administrator in	dicated immediately after					
	he was notified of	of Resident #31 leaving					
	the building, he	went to the apartment and					
	walked him back	to the facility. The					
	Administrator in	dicated the housekeeper					
	was informed no	t to let residents out of					
	the building unle	ss authorized by the					
	nursing staff or A	Administrator. The					
	Administrator in	dicated he did not report					
		diana State Department					
	of Health becaus	•					
		ever, Resident #31 was					
		nderguard after the					
	incident.	J					
	The facility failed	d to report the unusual					
	<u> </u>	ement of Resident #31.					
		- ,					
	3. During daily a	exit conference on					
	2/28/12 at 3:15 A.M., the facility policy on "Abuse Prohibition, Reporting, and						
		id "Resident Leave of					
	investigation an	Tesident Leave of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155568	B. WIN			03/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORT ST		
WILLIAM	ISPORT NURSING	AND REHABILITATION		WILLIAI	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Absence" was re	quested.					
	The facility "Abı	· ·					
		nvestigation Policy and					
		12/10 was received on					
	2/29/12 at 9:45 A	A.M. The policy and					
	procedure includ	ed, but was not limited					
	to:						
	"Policy and Procedure: All abuse						
	allegations/abuse must be reported to the						
	Executive Director immediately, and to						
	resident's represe	entative within 24 hours					
	of the report. Fa	ilure to report will result					
	in disciplinary ac	etion, up to and including					
	immediate termi	nation It is the					
	responsibility of	every employee of					
	American Senior	Communities to not					
	only report abuse	e situations, but also					
		usual observations and					
	circumstances to	his/her immediate					
	supervisor The	ED/designee will report					
	_	rences, which include					
		hours of discovery, to					
		Care Division of Indiana					
	_	t of Health. Upon					
	_	e investigation, which					
	_	n 5 working days of the					
		ccurrence, a report of the					
		st be forwarded to the					
	_	Division of Health.					
	_	npleted investigation					
	_	t to Adult Protective					
İ		Isman, and Director of					
	501 11000, 0111000						

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Event ID: **B18511**

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155568	B. WIN	G		03/01/	2012
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP CODE		
					ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Operations Res	sident Abuse - Staff					
	member, volunte	er, or visitor: Any					
	individual who w	vitnesses abuse or has					
	suspicion of shal	l immediately notify the					
	charge nurse on t	the unit, which the					
	resident resides	.Definition of unusual					
	occurrences/ever	nt: An unusual					
	occurrence/event	is defined as any					
	happening not co	onsistent with routine					
		nursing facility, which					
	_	of may have the					
	_	sing injury to residents,					
	_	or damage of property					
		rrences are to be viewed					
		rposes of investigation					
	and follow-up"	•					
	una rono w up						
	The facility "Lea	ve of Absence" policy					
		ated 3/10 was received on					
	2/29/12 at 1:40 P						
	The policy and p	rocedure included, but					
	1 1	o, "Policy: It is the					
		ility that continuity of					
		ent Leave of Absence					
	_	Leave of absence					
	_	ian's order Nursing will					
		n's order for the resident					
		or leave of absence with					
	responsible party						
	_	Power of Attorney need to					
	_	nd out of the facility on					
		sence form The licensed					
	nurse will docum	nent resident status upon					

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Event ID: **B18511**

Facility ID: 000449

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	OF CORRECTION	IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CO	00 	COMI	E SURVEY PLETED 1/2012		
		100000	B. WING			1/2012		
WILLIAM		AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	leave from the fa from leave"	cility and upon return						
	3.1-28(2)(c)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		155568				03/01/	
		10000	B. WIN			00/01/	2012
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
WILLIAM	SPORT NURSING	AND REHABILITATION			IORT ST MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	1		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0226	483.13(c)						
SS=D	· ' '	MENT ABUSE/NEGLECT,					
		develop and implement and procedures that prohibit					
		eglect, and abuse of					
	residents and mi property.	sappropriation of resident					
	Based on record	review and interview, the	F02	26	F226 Develop/Implement		03/30/2012
	facility failed to	ensure their Abuse			Abuse/Neglect, etc. policiesTh	ne	
	Prohibition Polic	eies were followed related			facility must develop and implement written policies and	Ī	
	to reporting alleg	ged abuse immediately to			procedures that prohibit	ı	
		r, Director of Nursing, or			mistreatment, neglect and abu	ıse	
		r and failed to report an			of Residents and		
	_	nce to the State agencies.			misappropriation of Resident	no	
		actice impacted 2 of 2			property. What corrective action will be accomplished for those		
	_	idents [Resident #6 and			Residents found to have been		
	#15] reviewed for	-			affected by the deficient		
	_	of 1 residents [Resident			practice?1.) Resident #6 and	15	
		or elopement from a			had no negative adverse reactions and/or no negative		
	sample of 15 resi	_			psycho-social distress from the allegations. Both Residents	е	
	Findings include	:			identified acknowledged they not been abused.2.) All	had	
					allegations of abuse will be		
	1. On 2-29-12 at	t 9:45 A.M., the			investidated and reported to the	ne	
	Administrator pr	ovided the facility's			ISDH within 24 hours by the	-0 \	
	alleged abuse inv	vestigation for Residents			Executive Director/or designed Residents was informed to	2 3.)	
	#6 and #15. At t	hat time, a "Facility			express any concerns or		
	Incident Reportin	ng Form" was reviewed.			allegations of abuse to any sta	aff	
					member or the Executive Dire	ctor	
	The "Facility Inc	eident Reporting Form"			during Resident Council	lno	
	_	s not limited to, "Incident			03/16/12.4.) Resident #31 had negative outcome as a result of		
		at 2:20 P.M Residents			this incidentHow other Reside		
		dents #6 and #15] Brief			having the potential to be affe		
	_	ncident: During Resident			by the same deficient practice		
		icident. During Resident			be identified and what correcti	ve	

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Event ID: **B18511**

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155568	A. BUILDING			03/01/2012	
		133308	B. WIN			03/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORT ST		
WILLIAM	ISPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	Council meeting	it was identified that			actions will be taken?1.) All	_	
	[Certified Nursin	g Assistant #3] [CNA]			Residents have the potential to be affected 2.) No other Resident		
	had become roug	th with a couple of			was affected3.) Resident Cou		
	residents [Reside	ent #6 and #15] during			was informed to express any		
	their shower. W	hen questioned rough,			concerns or allegations of abu	ise	
	residents replied	with rushing through the			to any staff member or the		
	_	ate Action Taken:			Executive Director during	A 11	
		stion [CNA #3] was			Resident Council 03/16/12.4.) allegations of abuse will be	All	
	suspended for 3	-			investigated and reported to		
		restigation initiated			the ISDH within 24 hours by the	ne	
		•			Executive Director/or		
	' '	Executive Director [ED]			designeeWhat measures will l		
		ce Director [SSD],			put into place to ensure that the	ne	
		iewed with no findings,			deficient practice does no recur?1.) Executive Director w	/O.C	
	_	ents #6 and #15] who			re-educated by Nurse Consult		
	initially reported	that she was rough			on 03/09/12 to facility policy for		
	indicated during	interview conducted by			unusual occurrences (See		
	SSD that she was	s not rough, staff			attachment 2-1)2.) New		
	interviewed with	no findings to support			elopement and BIMs assessm		
	any allegation of	roughness Preventive			has been completed on 03/12 by the Social Services Director		
	measures taken:	Abuse in-service			and the Director of Nursing	1	
	scheduled for Th	ursday, December 22,			Servies to reveal Resident #3	1 is	
		estion was allowed to			cognitively impaired.		
	return to work ba				Wanderguard bracelet remain	in	
	evidence The "				place.4.) Care plan phoe conference was held on 03/12	1/10	
		was submitted to			with Resident #31 responsivle		
		partment of Health on			party. Responsivle party is in	,	
	12-19-11.	partificant of freathfoli			agreement with order that rea	ds	
	14-17-11.				"Resident may go LOA with		
	m e :::				Responsible Party." Responsi		
	_	stigation of the alleged			Party also agrees Residens m		
		out was not limited to the			be signed outu by friends/fam for outings.5.) All unusual	IIIC5	
	following inform	ation:			occurrences that meet the fac	ility	
					definition of unusual occrrence	-	
	A document title	d, "Monday December			will be thoroughly investigated		
	19, 2011." The o	locument included, but			and reported within 24-hours t	0	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLET				
		155568	B. WIN			03/01/	2012	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE			
10/11 1 10 8 4	ICDODT NUDCINO	AND DELIABILITATION		200 SHORT ST WILLIAMSPORT, IN 47993				
		AND REHABILITATION		WILLIAI	MSPORT, IN 47993			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE	
TAG		, , , , , , , , , , , , , , , , , , ,		IAU	the ISDH by the Executive		DATE	
		to, "2:30 P.M. Director of [DNS] received written			Director/or designeeHow the			
					corrective action will be monito			
	_	om December [2011] I meeting minutes stating			to ensure the deficient practice	•		
					will no recur?1.) Executive Director/or designee will rando	mly		
	_	nt[s] stated that one of the is a little rough with			interview staff members about			
		g care Following			abuse policies and procedures			
		e meeting minutes,			weekly for 4 weeks using the C	CQI		
	[CNA #3] was w				tool, then random interviews bi-weekly for 30 days then			
	building ED ar				quarterly. The results of these			
		idents from both halls a			interviews will be reviewed by			
	_	interviewed in addition to			CQI committee overseen by th	е		
		ents interviewed indicated			Executive Director. If 100% compliance is not achieved an			
	that they had no				action plan will be developed to			
	_	CNA #3] as previously			ensure compliance. (See			
		dent Council Activity			attachment 1-2)			
		ds Resident Council was						
	out of the building	Jpon return to the						
	_	gave a 1:1 inservice with						
	_	ector that reminded her						
		on of abuse that has been						
		ident Council will be						
	brought to attent							
	~	owing the Council						
	1	any allegations are						
	_	toe assessments were						
	completed with i							
	Completed with I	io areas noteu						
	During daily avi	t conference on 2/28/12 at						
	1 -	lent Council minutes						
	· · · · · · · · · · · · · · · · · · ·	ove incident were						
		ove meidem wele						
	requested.							

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Event ID: **B18511**

Facility ID: 000449

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	
		155568	B. WIN	G		03/01/	2012
NAME OF D	DROVIDED OD GLIDDI IED		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C.		200 SH	ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		45 A.M., Resident					
		for December 2011 were					
	received from the	e Administrator.					
		ouncil Minutes" dated					
	· · · · · · · · · · · · · · · · · · ·	e, included, but were not					
	limited to, "One	resident expressed to					
	writer that one C	CNA [CNA #3] is a little					
	rough when givin	ng her a shower. When					
	questioned does	she hurt you in any way					
	resident stated no	o she seems very strong					
	and has a very m	anly voice Residents					
	1	ways report it if they feel					
		way. This resident					
	· ·	t have said anything.					
		ted to always voice their					
		buse topics. Resident					
	stated I wasn't at	•					
	stated I wash t at	Jusea					
	The Activity Dir	ector was informed by					
	Resident #6 and	Resident #15 on					
	12/13/11, no tim	e, during the monthly					
		l meeting of an allegation					
		ctivity Director informed					
		Illegation 6 days later on					
	12/19/11.	and and and and					
	On 3/1/12 at 11.	30 A.M., Resident #6's					
	record was revie	·					
		re not limited to, diabetes					
		depression, hypertension,					
	and congestive h						
	and congestive n	cari ianuic.					
	A quarterly Mini	imum Data Set [MDS]					

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	OF CORRECTION OF CORRECTION 155568	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/01/2012			
	PROVIDER OR SUPPLIER SPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION			
	screening assessment dated 12/1/11 included, but was not limited to, "BIMS [Brief Interview Mental Status] 14 [cognitively intact], Bathing total assist with one person" On 3/1/12 at 11:40 A.M., Resident #15's record was reviewed. Diagnoses						
	included, but were not limited to, anxiety, depression, and hypertension.						
	A quarterly MDS screening assessment dated 10/2/11 included, but was not limited to, "BIMS 13 [cognitively intact], Bathing physical help with one assist"						
	2. Tour of the facility was initiated on 2/27/12 at 10:45 A.M. with the DNS. Resident #31 was described as interviewable, ambulated with a rolling walker, had a wanderguard for elopement behaviors.						
	In an interview at that time, the DNS indicated Resident #31 had attempted to elope from the facility 1-2 months ago therefore the wanderguard was placed again. She indicated Resident #31 left the facility with a friend who lived in the apartments located on the property. She indicated Resident #31 had worn a wanderguard in the past; however, his condition had improved since that time with no elopement behaviors.						

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155568 A. BUILDING	00	COMPLETED 03/01/2012
NAME OF PROVIDER OR SUPPLIER STREET ADDR 200 SHORT	RESS, CITY, STATE, ZIP CODE T ST PORT, IN 47993	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
On 2/28/12 at 1:25 P.M., Resident #31's record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, diabetes mellitus, and atrial fibrillation. An "Elopement Risk Assessment" dated 4/16/11 included, but was not limited to, "Resident has a history of eloping from home or facility yes, Resident experiences increased confusion at certain times of the day yes, Resident walks/paces about the facility and is often seen trying to open exit doors yes, Resident has been assigned a security bracelet [wanderguard] yes" A "Physician's Orders" dated 8/11/11, no time, included, but was not limited to, "May discontinue wanderguard Care plan update, no exit seeking behavior" A "Social Service Progress Notes" dated 11/4/11, no time, included, but was not limited to, "Resident quarterly Minimum Data Set [MDS] completed Brief Mental Status [BIMS] is 12 [moderately cognitively impaired] Resident scored higher on this BIMS than in the past Resident states he gets fidgety and restless due to being out working instead of sitting in the facility Resident is active and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155568	B. WING			03/01/	2012
	PROVIDER OR SUPPLIE	R G AND REHABILITATION		200 SH	.DDRESS, CITY, STATE, ZIP CODE DRT ST MSPORT, IN 47993		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	social" A "Progress No	tes" dated 12/9/11 at 6:35					
	P.M., included, "Resident alert	but was not limited to, and oriented to person, Does have memory					
	P.M., included, "Wanderguard v	tes" dated 1/22/12 at 2:02 but was not limited to, working and placement seeking noted"					
	time, included, "Wanderguard pelopement assess history of elope	Orders" dated 1/22/12, no but was not limited to, blacement due to new ss [sic] and triggers Also ment attempts Care plan I for exit seeking"					
	P.M., included, "Resident's annutime BIMS 8 impaired] Res	tes" dated 1/23/12 at 2:23 but was not limited to, all MDS completed at this [cognitively moderately ident's care plans focus on erm, and elopement					
	9:35 A.M., incluto, "Elopement Resident has his home or facility	Report" dated 1/23/12 at uded, but was not limited Risk Assessment: story of eloping from yes, Resident reased confusion at certain					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568		LDING	NSTRUCTION 00	(X3) DATE COMPI 03/01.	ETED
	PROVIDER OR SUPPLIER	AND REHABILITATION	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE DRT ST MSPORT, IN 47993	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	seen trying to op the resident been bracelet yes" In an interview 2 with the Adminis#31's elopement indicated Reside facility by a houseworks for the facility property. #31 walked the facility property. #31 walked the facility property. #31 walked the nur informed the Administrator in he was notified of the building, he walked him back Administrator in was informed not the building unleading staff or Administrator in the incident to Info Health because elopement; howe	the facility and is often en exit doors yes, Has assigned a security /29/12 at 11:15 A.M., strator regarding Resident attempt on 1/22/12, he at #31 was let out of the sekeeper who no longer ility. The Administrator at #31 was with a friend apartments located on the He indicated Resident ariend home and the aim out of the facility, se working who then ministrator. The dicated immediately after of Resident #31 leaving went to the apartment and to the facility. The dicated the housekeeper to let residents out of se authorized by the administrator. The dicated he did not report diana State Department					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	00	(X3) DATE COMPL		
THIND I LITTLE	or conduction	155568		LDING		03/01/	
		10000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/	2012
NAME OF I	PROVIDER OR SUPPLIER				ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	DROUIDERIC DI ANI OF CONDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	d to report the unusual					
	occurrence/elope	ement of Resident #31.					
	3 During daily (exit conference on					
	1	A.M., the facility policy					
		bition, Reporting, and					
		d "Resident Leave of					
	Absence" was re						
		1					
	The facility "Abu	ase Prohibition,					
	Reporting, and In	nvestigation Policy and					
	Procedure" dated	12/10 was received on					
	2/29/12 at 9:45 A	A.M. The policy and					
	procedure includ	ed, but was not limited					
	to:						
	"Policy and Proc	edure: All abuse					
	*	e must be reported to the					
		or immediately, and to					
		entative within 24 hours					
		ilure to report will result					
	_	etion, up to and including					
	immediate termin						
	responsibility of	every employee of					
	American Senior	Communities to not					
	only report abuse	e situations, but also					
		usual observations and					
	circumstances to	his/her immediate					
	_	ED/designee will report					
		rences, which include					
		hours of discovery, to					
	_	Care Division of Indiana					
		t of Health. Upon					
	completion of the	e investigation, which					

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Event ID: **B18511**

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED			
12.212.11(155568	A. BUILDING		03/01/2012			
	1	B. WING	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER		ORT ST				
WILLIAM	SPORT NURSING AND REHABILITATION	WILLIAMSPORT, IN 47993					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG	must occur within 5 working days of the	TAG	BLI (CLE.C.)	DATE			
	reporting of an occurrence, a report of the						
	investigation must be forwarded to the						
	Long Term Care Division of Health.						
	Copies of the completed investigation						
	must also be sent to Adult Protective						
	Services, Ombudsman, and Director of						
	Operations Resident Abuse - Staff						
	member, volunteer, or visitor: Any						
	individual who witnesses abuse or has						
	suspicion of shall immediately notify the						
	charge nurse on the unit, which the						
	resident residesDefinition of unusual occurrences/event: An unusual						
	occurrence/event is defined as any						
	happening not consistent with routine						
	operation of the nursing facility, which						
	may have caused of may have the						
	potential for causing injury to residents,						
	visitors, or loss or damage of property						
	All unusual occurrences are to be viewed						
	as serious for purposes of investigation						
	and follow-up"						
	2.1.20()						
	3.1-28(a)						
l							

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Event ID: **B18511**

Facility ID: 000449

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING 00			ETED
		155568	B. WING			03/01/	2012
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		200 SH	ORT ST		
WILLIAM	ISPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services pro facility must be p	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons with each resident's written					
	Based on observed interview, the fact staff washed their medication admit 1 of 9 resident mobserved during (Residents #27, 22 Findings included During an observed pass, on 2/28/12 had completed the administration for second bed, and room, when Resident #27's becontroller and additional to the controller and additional to the con	inistration. This effected nedication preparations medication pass. 28 and 30) Example 28 and 30) Example 28 and 30) Example 28 and 30) Example 29 and 30) Example 20 and 30) Exampl	F023	82	F282 Services by qualified persons/per care planThe services provided or arranged the facility must be provided by qualified persons in accordance with each Resident's written pof careWhat corrective actions will be accomplished for those Residents found to have been affected by defecient practice? Residents #27, 28 and 30 wernot harmed2.) Staff are now howashing cirrectly during medication passHow other Residents having the potentiato be affected by the same deficient practice will be identified and what correctivactions will be taken?1.) All Residents have the potential to be affected2.) No other Reside were identified to have been affected3.) All Licensed and non-licensed staff was re-educated on 03/14/12 by the Executive Director to facility have washing policy and procedure (See attachment 3-1)What measures will be put into place ensure that the deficient practices not recur?1.) LPN#2 was immediately counseled by the DNS on 02/28/12 and provide verbal 1:1 re-education the saidate2.) DNS or designee will	y ce lan se la se lan se la se lan se la se lan se la	03/30/2012

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Facility ID: 000449

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155568	B. WIN	IG		03/01/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN				ORT ST		
WILLIAM	ISPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		A.M., indicated the			complete random audits of all Licensed nursing personnel		
	following:				weekly to observe hand washi	na	
					during medication administration		
	"Procedure: M	edication Pass:			on all shifts for 30 days, then		
	When preparing	medications the staff will			bi-weekly for 30 days then		
	follow the facilit	y's hand			quarterly to ensure appropriate		
	washing/sanitizii	ng policy and			hand washing occurs using the CQI skills validation checkoff.	=	
	procedure"				(See attachment 3-2)How the		
					corrective action will be monito		
	A facility policy	for "Hand Washing			to ensure the deficient practice		
Procedure, dated 1/2011, received from					will not recur?1.) All findings w		
		Jursing on 2/29/12 at 9:00			be submitted and reviewed dumonthly CQI meetings oversee		
	A.M., indicated	•			by the Executive Director. If the		
	Timi, maioutou	ine rone wing.			threshold of 95% is not achieve		
	" C 1 Decents	minating hands can refer			an action plan will be develope	ed	
		soap and water or using			to ensure compliance2.)		
					Completion Date: 03/30/12		
		mittently in place of soap					
		econtaminate hands					
		having direct contact with					
	1 ^	Decontaminate hands					
	after contact with	n inanimate objects"					
	_	iew with the Director of					
	_ ·	12 at 11:45 A.M., she					
		would all be inserviced					
	regarding the lac	k of hand washing while					
	passing medicati	ons.					
	3.1-35(g)(2)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COM		COMPL	ETED	
		155568	B. WIN			03/01/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				IORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0371 SS=F	483.35(i) FOOD PROCUR	-					
33 - F		RE/SERVE - SANITARY					
	The facility must						
	•	from sources approved or					
	considered satisf	factory by Federal, State or					
	local authorities;						
		e, distribute and serve food					
	under sanitary co		F02				00/20/2010
		ation, interview and	F03	/ I	F371 Food Procure, Store/Prepare/Serve -		03/30/2012
	record review, th	e facility failed to ensure			SanitaryThe facility must-1.)		
	that 1 of 1 Dietar	y Cook washed her			Provide food from sources		
	hands and used d	isposable gloves in the			approved or considered		
		during the serving of 1			satisfactory by Federal, State	or	
		This deficiency had the			local authorities; and2.) Store,		
		ct 63 of 64 residents who			prepare, distribute and serve f		
	•	om 1 of 1 facility			under sanitary conditions What	t	
	kitchens. [Dietai				corrective actions will be accomplished for those		
	Kitchens. [Dictai	y COOK #1]			Residents found to have bee	n	
	TO 11 1 1 1 1				affected by the deficient		
	Findings include	:			practice?1.) No Residents we	re	
					directly affected2.) Dietary sta		
	On 2/29/12 at 11	:20 A.M., the lunch meal			are now completing hand		
	food service line	was observed.			washing and glove usage		
					correctlyHow other Residents		
	Dietary Cook #1	was observed to have			having the potential to be affect by the same deficient practice		
	disposable glove	s on while checking the			will be identified and what		
		he prepared food on the			corrective actions will be		
	_	was observed to touch			taken?1.) ALI Residents had the	ne	
		th one gloved finger			potential to be affected2.) Diet	ary	
					cook was counseled and provi	ided	
		se the back of her gloved			1:1 re-education by Dietary		
	hand to wipe her	nose.			Manager on 02/29/12 to	ı	
					re-educate dietary department hand washing & glove use Wh:		
	_	attempt to remove the			measures will be put into pla		
	gloves and wash	her hands, the action was			to esnure that the deficient		
	called to her atter	ntion. The cook			practice does not recur?1.) A	dl .	
					dietary employees was		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155568	B. WING		03/01/2012	
NAME OF E	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE		
				IORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION	WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		s not aware that she had		re-educated to dietary departn hand washing/glove use by the		
		emoved her gloves and		Dietary Manager on 02/29/12.		
	threw into trash	barrel. She obtained a		(See attachment 4-1)2.) All		
	clean pair of disp	posable gloves, and while		Dietary staff was re-educated	on	
	holding in her le	ft hand, reached into a		dietary department hand		
	covered plastic b	oin for a large ladle. She		washing/glove use policy and		
	placed the ladle	in the pan holding the		procedures by the Executive Director on 03/14/12 (See		
	day's soup entrée	e, and then put the gloves		attachment 4-2)3.) DM/or		
		washing her hands.		designee will complete weekly		
		-		dietary employee hand washir	-	
	Using tongs, the	cook placed slices of		skills validation for both shifts		
	"	omato, and pieces of		30 days, then complete bi-wee for both shifts for 30 days then		
		to accompany the ham		quarterly until continued		
	salad lunch entré			compliance is achieved. (See		
	Salaa lahen entre	ve.		attachment 4-3)How the		
	After 5 6 meal to	rays had been prepared		corrective action will be monito		
		eart, the Dietary Manager		to ensure the deficient practive will not recur?1.) The results of	l l	
	_	concern about the holding		the skills validations will be	'	
				reviewed by the CQI committe	e	
		ained for the ham salad.		overseen by the ED. If the		
				threshold of 95% is not achiev	l l	
	salad and prepar	•		an action plan will be develope to ensure compliance2.)	ea	
	sandwiches for t	he lunch meal entrée.		Completion date: 03/30/12		
	0 1 //1 //	and all the state of				
		ent to the telephone on the				
	· · · · · · · · · · · · · · · · · · ·	at the far side of the				
		I picked it up to make a				
	call. She was we	earing the same gloves.				
	On 3/1/12 at 9:53	·				
	Administrator pr					
		e forms. In an interview				
	at that time, he in	ndicated these				
	policies/procedu	res were "specific to the				
	dietary departme	ent."				
	I		1	I .	l l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND FLAN	OF CORRECTION	155568		LDING	00	03/01/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R		200 SH			
WILLIAM	ISPORT NURSING	AND REHABILITATION			MSPORT, IN 47993		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	The first policy/	procedure was titled					
		procedure was titled " and had an original date					
	-	pdates on 03/04 and					
		icy/procedure included,					
	_	ted to, the following:					
	out was not min	ica to, the following.					
	 "POLICY: Diet	ary staff will wash hands					
after touching bare human body parts other than clean hands and clean, exposed							
		; after coughing,					
	-						
	sneezing or using a handkerchief or disposable tissue; after handling soiled						
	•	nent, or utensils; during					
		; before touching food					
		surfaces; before placing					
		and after engaging in					
	~	hat contaminate hands."					
	The second police	cy/procedure was titled					
	"Use of Gloves,"	" and had an original date					
	of 02/02 with up	odates on 05/06 and 04/11.					
	This policy/proc	edure included, but was					
	not limited to, th	ne following:					
	"POLICY: Glov	ves will be worn when					
	_	rectly with hands to					
		eria are not transferred					
		andler's hands to the					
	product being se	erved.					
	PROCEDURE:						
	1. Hands will be	e washed when entering					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL1	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	
		155568	B. WING			03/01/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
10/11 1 10 8 4	CDODT NUIDCING	AND DELIADILITATION			ORT ST		
VVILLIAIVI	SPORT NURSING	AND REHABILITATION	V	VILLIAN	MSPORT, IN 47993		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	AG	DEFICIENCT)		DATE
		pefore putting on the					
	gloves						
	2 (1)	. 121 1 1 1 1					
		st like hands; they get					
		a contaminate surface is					
	_	must be changed and					
	hands washed.						
		g or sneezing into hands,					
or touching hair or face							
* After handling boxes, crates or							
packages							
		touch a contaminated					
	surface."						
	The "Retail Food						
	•	rements, Title 410 IAC					
	· ·	fective November 13,					
	•	ved on 3/2/12. The					
		o hand washing and					
	_	ed, but was not limited					
	to, the following	:					
		Food employees shall					
		and exposed portions of					
	_	cified under section 128					
		ediately before engaging					
		on, including working					
	-	od, clean equipment and					
	•	vrapped single-service					
	_	ticles and the following:					
	(1) After touchin	g bare human body parts					
	other than clean	hands and clean, exposed					
	portions of arms	(4) After coughing,					
	sneezing, or usin	g a handkerchief or					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155568		A. BUILDING B. WING	00 	COMPLETED 03/01/2012			
	PROVIDER OR SUPPLIER SPORT NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	disposable tissue (6) After handling soiled surfaces, equipment, or utensils (9) Before touching food or food-contact surfaces. (10) Before placing gloves on hands" "Section 246(a) If used, single-use gloves shall be: (1) used for only one (1) task, such as working with ready-to-eat food or with raw animal food; (2) used for no other purpose; and (3) discarded when: (A) damaged or soiled; or (B) interruptions occur in the operation" 3.1-21(i)(2) 3.1-21(i)(3)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155568	A. BUII B. WIN			03/01/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L					
WILLIAM	SPORT NURSING	AND REHABILITATION	200 SHORT ST WILLIAMSPORT, IN 47993				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=E	SPREAD, LINEN						
	•	establish and maintain an					
		Program designed to					
		anitary and comfortable					
		I to help prevent the					
	development and transmission of disease and infection.						
	 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; 						
	(2) Decides wha	t procedures, such as					
	isolation, should	be applied to an individual					
	resident; and						
		ecord of incidents and					
	corrective action	s related to infections.					
		pread of Infection					
	` '	ection Control Program					
		a resident needs isolation to					
		ad of infection, the facility					
	must isolate the						
		ust prohibit employees with a					
		isease or infected skin					
		et contact will transmit the					
	disease.	ct contact will transmit the					
		ust require staff to wash their					
		direct resident contact for					
		hing is indicated by accepted					
	professional prac						
	(c) Linens						
		handle, store, process and					
		so as to prevent the spread					
	of infection.						
	Based on observa	ation, record review and	F04	41	F441 Infection Control, Preven		03/30/2012
	interview, the fac	cility failed to ensure			Spread, LinensThe facility mus	st	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155568		LDING		03/01/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
\A/II A B A	IODODT NUIDOINO	AND DELIABILITATION			ORT ST		
WILLIAW	ISPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	proper handwasł	ning during medication			establish and maintain an		
	administration as	nd to initiate the two step			infection control program		
		skin testing, for a newly			designed to provide a safe,		
	` ′	nt. This impacted 1 of 9			sanitary and comfortable	nt.	
		•			environment and to help preve the development and	#IIL	
		ved during medication			transmission of diseases and		
	^	Residents reviewed for			infection.(a.) Infection Control		
	_	ample of 15. (Residents #			ProgramThe facility must		
	27, 28, 30 and 40	6)			establish and infection control		
					program under which it -(1.)		
	Findings include	:			Investigates, controls, and		
					prevents infections in the		
	1 During an ob	servation of a medication			facility;(2.) Decide what		
					procedures, such as isolation,	lual	
		at 9:05 A.M., LPN #2			should be applied to an individ Resident; and (3.) Maintain a	iuai	
	had completed the				record of incidents and correct	tive	
	administration fo	or Resident # 28, in the			actions related to infections(b.		
	second bed, and	was starting to leave the			Preventing Spread of Infection		
	room, when Res	sident #27, in the first			When the infection control	` '	
		sistance adjusting the			program determnines that a		
	· ·	LPN #2 searched under			Resident needs isolation to		
					prevent the spread of infection	١,	
		"s bed sheets, found the			the facility must isolate the		
		ljusted the head of the			Resident(2.) The facility must		
	bed. LPN #2 left	the room and prepared			prohibit employees with		
	Resident #30's r	nedications with out			communicable disease or infected skin lesions from directions	ct	
	washing her han	ds or using hand			contact with Residents or their		
	sanitizer.	2			food, if direct contact will trans		
	barrerzer.				the disease(3.) The facility mu		
	A facility mali	for "Madigation			require staff to wah their hands		
	A facility policy				after each direct Resident con	tact	
		Guidelines, dated 7/2011,			for which hand washing is		
		e Director of Nursing, on			indicated by accepted		
	2/29/11 at 9:00 A	A.M., indicated the			professional practice(c.)		
	following:				LinersPersonnel must handle,		
					store, process and transport linens so as to prevent the spr	ead	
	"Procedure: M	edication Pass:			of infectionWhat corrective	cau	
		medications the staff will			actions will be accomplished for	or	
	I when brebaring	medications the Staff will	1		l		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED
		155568	B. WIN			03/01/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ORT ST	
10/11 1 10 8 4	CDODT NUDCING	AND DELIABILITATION				
VVILLIAIVI	SPORT NURSING	AND REHABILITATION		WILLIA	MSPORT, IN 47993	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	follow the facilit	y's hand			those Residents found to have	:
	washing/sanitizir	ng policy and			been affected by the deficient	
	procedure"	-8 F			practice?1.) Residents #27, 28	
	procedure				and 30 were not harmed2.) Sta	
		0 11 1 1:			are now hand washing correct	ly
		for "Hand Washing			during medication pass How	
	Procedure, dated	1/2011, received from			other Residents having the	
	the Director of N	fursing on 2/29/12 at 9:00			potential to be affected by the	
	A.M., indicated t	he following:			same deficient practice will b	
	,				identified and what corrective	9
"C. 1. Decontaminating hands can refer				actions will be taken?1.) All Residents have the potential to	,	
				be affected2.) No other Reside		
	to washing with soap and water or using				were identified to have been	1110
	alcohol gel intermittently in place of soap				affected3.) All Licensed and	
	and water3. Decontaminate hands				non-licensed staff was	
	before and after l	naving direct contact with			re-educated on 03/14/12 by the	e
		Decontaminate hands			ED to facility hand washing po	
	-				and procedures (See attachme	ent
	arter contact with	inanimate objects"			3-1)What measures will be put	:
					into place to ensure that the	
	During an intervi	iew with the Director of			deficient practice does not	
	Nursing, on 3/1/2	12 at 11:45 A.M., she			recur?1.) LPN#2 was immedia	tely
	indicate the staff	would all be inserviced			counseled by the DNS on	
	regarding the lac	k of hand washing while			02/28/12 and provided a verba 1:1 re-education the same date	
	passing medicati	-			DNS or designee will complete	,
	passing incurcati	ons.			random audits of all Licensed	'
					nursing personnel weekly to	
		ecord of Resident #46			observe hand washing during	
	was reviewed on	2/27/12 at 1:30 P.M. He			medication administration on a	ıll
	was admitted to t	the facility on 11/21/11.			shifts for 30 days, then bi-weel	kly
					for 30 days then quarterly to	
	Diagnoses includ	led, but were not limited			ensure appropriate hand wash	_
	_	stage renal disease and			occursHow the corrective action	
		i stage tenai disease and			will be monitored to ensure the	
	diabetes.				deficient practice will not	
					recur?1.) All findings will be	
	A review of the '	Resident Immunization			submitted and reviewed during montly CQI meetings overseer	•
	and Health Histo	ry Form" indicated a TB			the ED. If the threshold of 95%	
		e on 2/6/12 and read on			not achieved an action plan wi	
	brill test was doll	on 2/0/12 and read on	- [I hat dome you am action plan wi	"

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Event ID: **B18511**

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
	155568	A. BUILDING		- 03/01/2012	
		B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		IORT ST		
WILLIAM	ISPORT NURSING AND REHABILITATION		MSPORT, IN 47993		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG		DATE	
	2/8/12. A second TB skin test was done		be developed to ensure compliance2.) Completion dat	۵.	
	on 2/22/12 and read on 2/24/12. Both		03/30/12What corrective actio		
	results were 0 millimeters.		will be accomplished for those		
			Residents found to have been		
	During an interview with the Expositive		affected by the deficient	20	
	Director, on 3/1/12 at 3:00 P.M., he		practice?1.) Resident #46 had negative adverse reactions2.)	110	
	indicated the two step Tb skin testing was		Resident #46 was administere	d	
	not done when Resident #46 was admitted		the 2nd step PPD with negative	re	
	to the facility.		resultsHow other Residents having the potential to be affe	ntod	
			by the same deficient practice		
	3.1-18(e)		be identified and what correcti		
	3.1-18(1)		actions will be taken?1.) All		
			Residents have the potential t	0	
			be affected2.) A 100% chart review was completed on		
			03/14/12 by the DNS and ADN	IS	
			to ensure no other Residents		
			were affected, no other Reside		
			were identifiedWhat measures will be put into place to ensure		
			that the deficient practice does		
			not recur?1.) DNS and ADNS		
			were re-edcuated to facility		
			infection control/TB policy by t		
			DNS Specialist on 03/09/122.) Licensed nursing staff was	All	
			re-educated to facility policy a	nd	
			procedure on tuberculosis3.)		
			ADNS/or designee will comple		
			TB audits on all new admissio coming into the facility dailiy for		
			30 days, weekly for 30 days, t		
			bi-weekly for 30 days to ensur		
			100% compliance is		
			achieved. How the corrective action will be monitored to ens	uro.	
			the deficient practice will no	buic	
			recur?1.) Audits will be submit	ted	
			for review to the CQI committee	ee	
			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155568	B. WING		03/01/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				IORT ST	
WILLIAM	SPORT NURSING	AND REHABILITATION	WILLIA	MSPORT, IN 47993	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				overseen by the ED. If the threshold of 100% is not achie	wed
				a plan of action will be develop	
				to ensure compliance.2.)	
				Completion date: 03/30/12	
			1	1	

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